WISCONSIN MEDICAID "PHARMACY"
STAT-PA DRUG WORKSHEET FOR SSRI DRUGS

The "pharmacy" side of this optional worksheet records information necessary to complete the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) process. The "prescriber/pharmacy" side records clinical documentation.

Name – Patient	

The STAT-PA system will ask for the following items in the order listed below:

GENERAL INFORMATION

Wisconsin Medicaid Provider Number	___ ___ ___ ___ ___ ___ ___ ___
Patient Medicaid Identification Number	___ ___ ___ ___ ___ ___ ___ ___ ___ ___
National Drug Code	___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Prescriber's Drug Enforcement Administration Number	___ ___ ___ ___ ___ ___ ___ ___
Diagnosis Code Use the most appropriate *International Classification of Diseases, Ninth Revision (ICD-9), Clinical Modification* diagnosis code. The decimal is not necessary.	
Place of Service (Patient Location) Use patient location code "**00**" (Not Specified), "**01**" (Home), "**04**" (Long Term/Extended Care), "**07**" (Skilled Care Facility), or "**10**" (Outpatient).	___ ___
Date of Service The date of service may be up to 31 days in the future, or up to four days in the past.	
Days' Supply Requested*	

STAT-PA QUESTIONS

1. Is this patient currently stabilized on the requested SSRI? If yes, press "1." If no, press "2."
    a. If yes, the PA request may be approved for up to 365 days.
    b. If no, the provider will be asked:
2. Has the patient tried and failed fluoxetine therapy? If yes, press "1." If no, press "2."
    a. If yes, the PA request may be approved for up to 365 days.
    b. If no, the provider will be asked:
3. Is there documentation of a clinical contraindication to using fluoxetine to treat this patient? If yes, press "1." If no, press "2."
    a. If yes, the PA request may be approved for up to 365 days.
    b. If no, the provider will receive the following message: "Your PA request requires additional information. Please submit your request on paper with complete clinical documentation."

STAT-PA RESPONSE

Assigned PA Number	___ ___ ___ ___ ___ ___ ___
First Date of Service	
Expiration Date	
Number of Days Approved	

ADDITIONAL INFORMATION

Prior Authorization is required for the following SSRI drugs: Zoloft®, Prozac Weekly®, Paxil® (Brand and Generic), Paxil CR®, Celexa®, Lexapro®, Pexeva® (subject to rebate agreement)

Prior authorization is not required for generic fluoxetine.

*Days' supply requested equals the total days requested for the PA. For example, for a one-year PA, providers should enter "365."

Wisconsin Medicaid "Prescriber/Pharmacy"
Clinical Documentation for SSRI Prior Authorization

This is an *optional* form that patients, pharmacists and physicians may use to obtain or maintain clinical documentation supporting medical necessity of SSRI drugs requiring PA. We encourage you to use this form to facilitate the PA process. Providers must maintain all documentation, such as optional worksheets, that supports medical necessity and claim information in their records for a period not less than five years. Wisconsin Medicaid recommends providers maintain the related STAT-PA worksheet in their files. Documentation retained in other formats must be readily retrievable and available, if requested.

Name – Prescriber		Phone# Fax #
Name – Pharmacy		Phone# Fax #
Name – Patient		Date of Birth
Patient Identification Number		ICD-9
Diagnosis		
Drug Prescribed	☐ Celexa ☐ Lexapro ☐ Paxil ☐ Paxil CR ☐ Pexeva ☐ Prozac weekly ☐ Zoloft ☐ OTHER _____	

CLINICAL INFORMATION – PHARMACY TO MAINTAIN THIS INFORMATION

Indicate clinical reason(s) an SSRI other than fluoxetine is required for this patient. Check all that apply.

☐ Patient currently stabilized on requested SSRI drug.

☐ This recipient previously tried and failed on fluoxetine therapy.
    Indicate reason for failure

    ☐ Fluoxetine Not Effective   ☐ Side Effects   ☐ Adverse Event(s)

    ☐ Other _____

☐ Fluoxetine is medically contraindicated for this patient due to one or more of the following reasons

    ☐ Fluoxetine is not medically accepted therapy for the stated diagnosis.

    ☐ Drug-Drug Interaction(s)
        List_____

    ☐ Fluoxetine adverse effect(s)
        List_____

    ☐ Other specific medical contraindication(s) not listed above
        Describe specific medical contraindications to using fluoxetine for this patient.

Prescriber Information: Indicate supporting reference for medical contraindication.

☐ Package Insert (PDR)   ☐ MicroMedex   ☐ AHFS
☐ USP-DI   ☐ Facts & Comparisons   ☐ AMA Drug Information
☐ Medical Literature (Identify) _____   ☐ Other _____

SIGNATURE – Prescribing Provider	**Date Signed**

Pharmacy Information: Indicate how supporting reference information was obtained.

☐ Information obtained by telephone or from prescription order. ☐ Information obtained from patient.
☐ Information obtained elsewhere.